Summary of HFS 75 Public Hearing Testimony
Including Written Comments and Departmental Responses

Positive remarks: Supportive of inclusion of UPC and ASAM to standardize placement criteria and language for treatment providers, Medicare, Medicaid, private indemnity companies, managed care. WAADAC & WAAODA support the standards as written. Can see Wisconsin regain the status of being a leader in the substance abuse service system. UPC is best for the client. HFS 75 reflects the current treatment trends, including the need for a Clinical Supervisor. Request that you implement these rules immediately.

Rule Reference	Comment	Departmental Response
HFS 75.01 (l)(a)	Provide additional training in Wisconsin UPC once HFS 75 standards are approved. (#5, #8 and #37)	Training will be provided once HFS 75 is promulgated.
	How will disputes be resolved if a payer's criterion isn't similar to UPC or ASAM? (#21 and #32)	DHFS will establish and implement a process for reviewing alternative criteria.
	Previous discussion stated that there would be some language included about a state committee to review a payer's criteria if other than UPC or ASAM. (#22)	DHFS will establish and implement a process for reviewing other criteria.
	Defined levels of care in WI-UPC do not mesh with s. 632.89, Stats. There are no Current Procedural Terminology (CPT) Codes for transitional care. (#32)	This is a funder/payer issue, not an issue for the administrative rules. Transitional care is a defined level of care in s. 632.89, Stats. CPT codes are descriptive terminology and identifying codes for reporting medical services and procedures performed by physicians. There are codes for substance abuse in the CPT code, but they apply to medical interventions and not to the level of care that provides the treatment environment in which the medical interventions occur. In contrast, s. 632.89, Stats. funding levels apply to the treatment environment in which medical interventions occur.
	The health benefit cost for detoxification should be taken out of the substance abuse benefit in s. 632.89 and should be included under the general medical benefit. (# 17 and #32)	Acknowledged in the analysis section of HFS 75 and in HFS 75.02 (18) and (19). The rule defines detoxification service as a medical service that is designed to determine and stabilize the medical risks of withdrawal from alcohol and other drugs, and distinguishes detoxification from substance abuse treatment services which implement a patient's treatment and recovery plan.
	Develop WI-UPC for adolescents. (#35 and #41)	Presently the WI-UPC does not have placement criteria for adolescents who have substance abuse treatment issues, but ASAM has criteria. The Bureau of Substance Abuse Services will be developing adolescent placement criteria for incorporation into the WI-UPC.
	Strictly enforce WI UPC and give the utmost scrutiny to any placement criteria that are purported to be similar. (#17and #28)	HFS 75 requires that all certified substance abuse treatment providers use either WI-UPC or ASAM placement criteria in initial placement, transfer between levels of care and discharge from treatment. Any other criteria would need to be approved by the DHFS.

Rule Reference	Comment	Departmental Response
HFS 75.01 (1)(b)	Concern about payers approving reimbursement. (#3 and #27)	Standards cannot mandate a payer to fund services, but certain funders will be required to use Wisconsin UPC or ASAM placement criteria in placement decisions involving network providers that are certified substance abuse services.
HFS 75.02 (1) & wherever else it appears	Change "aftercare," which is not reimbursable, to "continuing care" wherever written. (#20 and #52)	Changed so that both terms mean the same thing.
HFS 75.02 (11)	Physicians, Psychologists and CICSWs grandfathered into the one-year window to be clinical supervisors should be required to pass national certification. (#2, #4, #19, #25, #33 and #64)	Physician, Psychologists and CICSWs are eligible to be clinical supervisors and are exempted from testing for Certified Clinical Supervisor (CCS). However, we have adjusted this section to ensure the expectation that clinical supervision includes exercise of supervisory responsibility in regard to at least: counselor development, counselor skill assessment and evaluation, staff management and administration, and professional responsibility.
	Opposes grandfathering of CICSWs to be clinical supervisors. (#28, #30, #31, #33, and #34)	No change. We have exempted physicians, psychologists and CICSWs from both grandfathering and from testing for CCS.
	Clinical supervisors should have specialty training in substance abuse treatment. (#4, #12, #21, #28, #29, #30, #33, #34, 39, #45, #48, #49, #52, #56 and #65) Delete requirement that CCS supervisors be CADC III. May be RADC I who attended CCS training (#5)	Agreed. All clinical supervisors are now required under HFS 75.02 (11) and in 75.03(4) (e) to be knowledgeable in psychopharmacology and in addiction treatment. No change. Training is not enough. At least 2 years of supervisory experience is required.
HFS 75.02 (11)	Does this include certified counselors? Does the clinical supervisor have to be "degreed" to be experienced? (#60)	Under the grand-fathering provision, a certified counselor with two years of documented clinical supervision in the areas of counselor development, counselor skill assessment and evaluation, staff management and administration, and professional responsibility may apply to be grand-fathered as a clinical supervisor to the Wisconsin Certification Board, Inc. or be trained and pass the test for certification as a clinical supervisor.
HFS 75.02 (11)	Proposed definition would be onerous for individuals who have been providing the function of Clinical Supervisor for years. Insert grand-father clause into the rules. Have this clause incorporate language making the grandfathering opportunity available for 1-year following promulgation of the rule. A letter from the employer verifying the person's function as an AODA Supervisor for the past two years would suffice. Without this provision, the Wisconsin County Human Service Association will not support promulgation of HFS 75. (#51)	Agreed. The grand-fathering clause is inserted in HFS 75.02 (11) definitions, with a time frame of one year from the date the rules are promulgated for applicants to apply under the grand-father clause.
HFS 75.02 (16)	Consider changing "Day Treatment" Service as it is confusing when services are provided anytime during day or evening. (#56)	No change. Day treatment is not defined by day time or night time, but by the number of hours of counseling provided to the patient per week,

Rule Reference	Comment	Departmental Response
		which is twelve or more hours per patient per week.
HFS 75.02 (20)	Add the word "primary" to substance abuse disorder in definition of dually diagnosed. Otherwise patient will be treated in Mental Health. (#56)	No change. Addition of "primary" is unnecessary. "Substance use disorder" as defined in the current edition of the Diagnostic and Statistical Manual of Mental Disorders, is a diagnosis of substance dependence or substance abuse, which in HFS 75 a patient is required to be treated by a substance abuse counselor, a physician knowledgeable in the practice of addiction medicine, or a psychologist knowledgeable in psychopharmacology and addiction treatment.
HFS 75.02 (26)	Keep group counselor/client ratio at 1:10. (#56 and #31)	No change. A ratio of 1:8 patients is the maximum group size for cost-effective group counseling.
HFS 75.02 (28) & (31)	Change "alcohol" to "alcohol and other drugs." (#20 and #52)	Agreed. Modified to include other drugs. These originally were taken as definitions from s. 51.45 (2) (d) and (f), Stats.
HFS 75.02 (30)	Intervention services were omitted as a service area. Want clarification as to whether this omission was intentional or an oversight. (#69)	Intervention services are incorporated into the outpatient level of care. There is no current intervention level of care criteria in the WI-UPC, but there is in the ASAM placement criteria.
HFS 75.02 (34)	Define qualifications of physicians & other medical personnel to include training or certification in addictionology. (#56) Doctors need to be educated on what medical detox is. (#27)	Modified to read physicians knowledgeable in the practice of addiction medicine, and are encouraged to seek certification in addiction medicine by the American Society of Addiction Medicine (ASAM), or certification in addiction psychiatry by the American Board of Psychiatry and Neurology. Psychologists are expected to be knowledgeable in psychopharmacology and in addiction treatment.
HFS 75.02 (50) & elsewhere	Change "treatment" to "counseling" (#20 and #52)	Changed treatment to counseling in definition and one place in HFS 75.13(1).
HFS 75.02 (80)	Clarify "Supervised clinical experience means. . ." gained? Does it mean no supervision is needed before a person gets their Masters Degree, only after? (#56)	Term is used in reference to a Masters-level mental health professional working with dually diagnosed patients. Definition is modified to clarify that the Clinical supervision occurs during the 3,000 hours after the master's degree is conferred. This applies to a mental health professional as described in Appendix B, # 8.
HFS 75.03 (3)(f)(h)	Pleased that the Wisconsin Certification Board (WCB) standards for competency of AODA professionals have been included in the rules. However, very concerned about the WCB's failure to include competency criteria for culturally diverse populations for certification requirements. We believe cultural competence to be an integral part of staff development and to the effective delivery of AODA Prevention, Intervention & Treatment Services to people in Wisconsin. (#69)	Agreed that there needs to be cultural competence as well as gender competence in the Wisconsin Certification Board standards. HFS 75.03 (3) (h) has been changed to address the need for competency in a range of areas regarding patient characteristics.
HFS 75.03 (4)(a)&(b)	Supports required certification for prevention services. (#46)	Support acknowledged.
HFS 75.03 (4)(b)	Include a time limit so that a well-qualified person with a criminal background history from 5 or more years ago could be hired without	No change. Section 50.065, Stats. and HFS 12 take precedence over particular DHFS rules.

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	going through appeal process. (#67 and #70-72)	
HFS 75.03 (4)(d)	Include CICSW along with physicians & psychologists who do not have to be substance abuse counselors in order to do counseling. (#37, # 40 and # 42).	No change. Exception is only for physicians and psychologists. All others who provide substance abuse counseling are to be substance abuse counselor as defined in HFS 75.02 (82).
HFS 75.03 (4)(d)	Strike out physicians and psychologists and allow substance abuse counseling to be done only by substance abuse counselors (#45 and #48).	Modified to require physicians knowledgeable in the practice of addiction medicine, and psychologists knowledgeable in psychopharmacology and in addiction treatment.
HFS 75.03(4) and (d)	This section states that all staff who provide counseling are to be substance abuse counselors in a certified AODA PROGRAM. We cannot find the staff requirements regarding treatment of patients who have a PRIMARY AODA DIAGNOSIS (regardless of dual diagnosis) in an OUTPATIENT MENTAL HEALTH setting. There are no requirements that state that master's level therapists with 3,000 hours treating patients in an Outpatient Mental Health Clinic need AODA certification or training to treat addiction. Is this the case? (#56)	HFS 75.03 (4)(d) requires that all staff in certified substance abuse services who provide substance abuse counseling be substance abuse counselors unless they are qualified physicians or psychologists. HFS 35 new rules for outpatient mental health clinics, now in rulemaking, require clinics serving dually diagnosed clients to demonstrate a substance abuse counselor is available on staff or as a consultant.
HFS 75.03 (6)	1. Appreciates standards, including training on suicide prevention & establishing procedures for death reporting. (#33) 2. Requests the State Methadone Authority to provide training in assessment & management of suicidal individuals as a statewide conference. (#67 and #70-72).	1. Acknowledged. 2. This training is necessary for all treatment staff, and should include staff working in other care levels.
HFS 75.03(10) and (11)	In-house admission requirements need to include a psychological evaluation of the client before entrance into a facility due to safety concerns. (#33)	No change. The screening that takes place before placement should assess safety concerns about a prospective patient.
HFS 75.03 (12)(c) and HFS 75.15 (15)(c)	Concerned about dual diagnosis services for uninsured. (#3).	Standards cannot mandate funding, but funders agree to use Wisconsin UPC or ASAM placement criteria.
HFS 75.03 (14)(a) 2.	Change #2 "Staffing for patients who attend treatment sessions more frequently than one day per week shall be completed at least every 30 days" to a "weekly staffing requirement." (#56)	No change. The treatment provider can choose to increase the staffing more frequently on a given patient as needed based on the patient's clinical needs and progress.
HFS 75.03 (20)	Evaluation process as defined will cost approximately 15% of the program budget. That is prohibitively expensive. Suggest agency evaluation plan be approved by State at time of certification. (#49)	Modified to allow more flexibility.
HFS 75.03 (20)	As in the previous standards, recognize evaluations already being done in an agency's accreditation by JCAHO, NCQA or CARF Commissions as fulfilling the measurement of outcome data requirements. (#31 and #35)	Modified to recognize evaluation by accreditation agencies, such as JCAHO, NCQA and CARF.

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	Allow a service to evolve its own evaluation system by adapting it to its clients & defining their own outcomes within the context of services provided. (#65)	Modified to allow more flexibility.
HFS 75.03 (20)	Funding sources often define expected outcomes for clients. Suggest agencies that desire certification develop an evaluation plan that represents their own achievable & affordable outcomes and this plan be approved by the State at the time the agency is certified. (#49)	Modified to allow more flexibility.
HFS 75.03 (21)	Under Communicable Diseases Screening, how will tuberculosis screening be implemented? How will an agency document a service's compliance and monitor this? What about the AODA Block Grant requirement between County/State contracts requiring use of the TB Memo Series? Will TB Memo Series satisfy this requirement? (**Comment from the audience -- Paul Strand.)**	Tuberculosis screening is required in # memo series (1994) updated from Administrator, and included in the state/county contract. Policy and procedures are required of the service and will be reviewed during the certification review process by the Division's Bureau of Quality Assurance.
HFS 75.04 (3)	There are some components in the prevention standards that require a certified prevention specialist. Define "similar prevention competencies." Can this be substituted for certified prevention professional in some instances? If an organization is without this specialist, will they lose their prevention funding? **(Comment from the audience --Ken Sann.)**	Similar prevention competencies can be demonstrated by completion of the prevention training curriculum developed by the Chippewa Valley Technical College as an associate degree program. A person completing this curriculum should forward an application for certification to the Wisconsin Certification Board, Inc. for determination of the current level of credential. A certified prevention service must meet the standards under section HFS 75.04.
HFS 75.12 (6) (g)	Clarify "a patient may not be an active patient . . . " (#22)	A patient in a Day Treatment Service under HFS 75.12 may not also be receiving treatment under HFS 75.10, 75.11 or 75.13.
HFS 75.13 (3) (a)3.	Change "full-time" to read "full-time or part-time substance abuse counselor," or remove "full-time," or "during hours of operation." (#5,#20 and 52)	No change. A substance abuse counselor must be present during all hours of operation of the service.
HFS 75.13 (3) (c)	Delete "at all times." (#5)	No change. A designated trained staff person must be on the premises when a service is in operation.
HFS 75.13 (5) (e)	Can a nurse practitioner be the medical director? (#5)	No. A medical director must be a physician knowledgeable in the practice of substance abuse treatment.
HFS 75. 14 (4) (2)	Clarify term "written agreement". Is informal MOA sufficient? (#8)	"Or through written agreement" has been changed to "under contract with the service."
HFS 75.15	The methadone maintenance rules are regressive and insensitive to patients as well as staff. They will cause a significant increase in costs to patients who are already struggling to pay required minimal fees. Proposed changes will jeopardize the quality of services that providers	HFS 75.15 has been revised following meetings with commentors to determine their specific areas of concern.

Rule Reference	Comment	Departmental Response
	are capable and qualified to administer. (#67 and #70-72)	
HFS 75.15 (4)(a)	Change to "the physician shall be easily accessible to the service when needed." (#59, #67 and #70-72)	Modified to be similar to the suggested language.
HFS 75.15 (4)(b)	Change "registered" to "licensed nurse". LPNs are capable of being well versed in methadone therapy, dispensing, & following a physician's orders. (#44, #67 and #70-72)	No change. An LPN has to be supervised by an MD or an RN. So there will be no benefit to changing to an LPN.
HFS 75.15 (4)(d)	Include registered alcohol/drug counselors & personnel who have the plan on file for employment. (#67, #68 and #70-72) Change certified substance abuse counselor to "certified and registered substance abuse counselors and counselors with a plan on file." (#59)	Changed to include a registered alcohol and drug abuse counselor 1.
HFS 75.15 (4)(e)	Agree with clinical supervisor, but there is need to grandfather CADC IIIs & others who have had years of experience in the role of a supervisor. (#67 and #70-72)	Grandfathering is allowed for up to one year for those counselors who have provided clinical supervision for at least two years in the areas of counselor development, counselor assessment and evaluation, staff management and administration and professional responsibility and who apply to the Wisconsin Certification Board, Inc.
HFS 75.15 (4)(e)	May certified counselors do clinical supervision? (#60)	Yes, under the grandfathering statement a certified counselor with two years of clinical supervision experience can apply to the Wisconsin Certification Board to be grandfathered.
HFS 75.15 (4)(e)	Is this proposal stating that we can only hire certified counselors? (#53)	A non-certified counselor who has a plan on file with the Wisconsin Certification Board, Inc. or a Registered Alcohol and Drug Counselor 1 may also provide services provided that person is supervised by a Clinical Supervisor who is certified by the Wisconsin Certification Board, Inc.
HFS 75.15 (5)(a)2.	Change to:....If the time period is less than one year, the person may be admitted for detoxification services for a period up to 180 days on the recommendation of the clinic physician. This is important for patients who have become dependent on a narcotic drug that was either prescribed or obtained illicitly. (#44)	No change. This is an FDA requirement.
HFS 75.15 (5)(a)3.	1) Requiring failure in 2 previous drug treatment services before being admitted for narcotic addiction treatment is not facing the reality of patients who are trying to hang on to their employment and recognize the need for treatment now & the type of treatment they need. (#67, #68 and #70-72) 2) Lack of previous program verification should not be a determining factor in the denial of admission to a drug treatment service. Patients need to be attended to in as quickly a manner as possible. (#59) 3) Abstinence-based & other AODA treatment programs don't always address withdrawal problems from opioid dependence. Opioid	Modified. Requirement of failure in 2 treatment services before admission to this level of care is dropped. Admission should be made using Patient Placement Criteria. Presently the American Society of Addiction Medicine (ASAM) has placement criteria that can determine placement into this level of care. Since HFS 75.01(1) (a) and 75.03(1) requires that placement into any detoxification or treatment levels of care require the use of Uniform Placement Criteria, The Department recommends that the ASAM criteria be the instrument used until WI-UPC develops and includes criteria for this level of care.

Rule Reference	Comment	Departmental Response
	withdrawal affects not only mother but fetus, & detox services are not readily available in hospital. It is not always wise to recommend detox for pregnant women without the benefit of traditional treatment services to help prevent relapse to narcotic use.(#44)	
HFS 75.15 (5)(a)4.	Delete "has" and change to "the person is strongly recommended to provide names, etc." (#67and #70-72) Difficult for patient to produce documentation as evidence of past treatment history. Often histories cannot be obtained due to closed facilities, past due accounts, etc. (#53) Past treatment history often is nearly impossible to obtain. Often we receive **no response** after repeated phone calls, faxes, etc. It often takes many weeks to obtain the information. This delays necessary treatment. (#68) Lack of resources is evident especially in 18-24 year olds. (#44)	No change. Coordination of patient care between providers is critical to continuity of care.
HFS 75.15 (5)(e)	1) Treatment would be unreachable due to costs if complete lab work-up & psychosocial assessment are needed. A patient's finances are often depleted by this time and it would be prohibitive to expect clinics to pick up this cost. (#67 and #70-72) 2) Complete lab work-up is costly and not necessary in all cases. The physician might order further tests after examining patient. Change psychosocial assessment to where available &/or referral made to appropriate services. (#59) 3) What is distinction between "preliminary" treatment plan and "initial" treatment plan? (#67 and #70-72)	#1. & #2. No change. The examination and lab work-up and psychosocial assessment are essential for the physician to determine if the client is eligible for narcotic treatment. #3. Changed to initial treatment plan.
HFS 75.15(5)(g)	Regarding 50 mile radius: If patient can get to and from the treatment facility, and if no treatment facility is in their rural area nor a physician willing to "take on" the rules & paperwork involved, then it should not matter how far. (#68) Should be an exception to 50-mile limit, with authorization from the SMA, because of the lack of services in certain areas of the state, especially rural areas? (#44)	Modified to allow the patient to request approval of an exception from the state methadone authority.
HFS 75.15 (5)(i) 2.b 2.c & 3.b.	1)It is not practical to notify central registry for changes such as: from liquid to disk or back again; increase or decrease in doses; and if treatment is interrupted & resumed. SMA would be flooded with paperwork. Agree to the information of patients being admitted & discharged to the central registry. (#67 and #70-72) Eliminate 2.b & 3.b as these dose changes are always from a physician's order & documented in the medical record. (#44) 2.c Patients admitted & discharged from program should be reported, but I question reporting of when treatment is "interrupted". (#59)	#1 Agreed. Requirement to report has been deleted in changes in the type or dosage of the drug. #2. Agreed. Requirement to report when treatment has been interrupted and resumed has been deleted.

Rule Reference	Comment	Departmental Response
HFS 75.15 (5)(i) 4.a & 4.b	a. Please clarify: a. "List the name & address of each central registry or acceptable alternative and each detoxification or narcotic treatment service for opiate addiction to which a disclosure will be made." b. Also clarify "Authorize a disclosure to any detox or narcotic treatment service for opiate addiction without naming the service." Does signing a blank release of info make it invalid or violate a patient's rights? (#44, #59, #67 and #70-72)	a. No change. These are requirements under the federal confidentiality regulations under 42 CFR Part 2 for patient consent of release of information. b. This requirement has been deleted. It is not allowable.
HFS 75.15 (5)(j) 8.	Include barbiturates and benzodiazepines in drug screening or analysis. (#44)	Agreed. Change has been made.
HFS 75.15 (5)(m)	Seems to infringe on patient' rights to require a person under continual supervision to provide written information release. Change "require" to "strongly recommend." (#59, #67 and #70-72)	No change. This is another area where it is absolutely essential to ensure coordination and continuity of care.
HFS 75.15 (9)(a) 7.	For reviewing & countersigning each treatment plan – Suggest this be: -At Initial treatment plan; - At 90 days; - At 6 months; - Annual & every 6 mos., unless revised sooner. (#44)	No change. Review and countersigning may be done on that schedule under current rule language, except that after the first year the requirement must stay at 4 times a year.
HFS 75.15 (9)(a)7.	Change "reviewing & countersigning each treatment plan 4 X annually to read "4 X for the first year of treatment, then every 6 months." (#59, #67 and #70-72)	No change. Review and countersigning may be done on that schedule under current rule language, except that after the first year the requirement must say at 4 times a year.
HFS 75.15 (9)(b) 4.	Define "and orders in a manner that prevents the onset of withdrawal symptoms." (#67 and #70-72)	Clarified by adding "physician" before "supervision" and "orders." A physician's orders state the manner that is to be used to prevent withdrawal symptoms.
HFS 75.15 (9)(d)	Delete "maximum of two years." Methadone therapy is long term maintenance therapy. Drug addiction is a disease. While there is no cure, there is treatment. (#44, #59, #67 and #70-72) Client has to be evaluated individually to continue in Methadone Maintenance. Some have made excellent progress on this program. Some have left, relapsed & returned. This is a "life-long" treatment for some. (14)(a) states duration & retention are directly correlated to rehab success. It says effort should be made to retain patients. Isn't this contradictory? (#68)	The 2-year maximum is retained as a general rule with language added as to what documentation is required to justify longer service provision.
HFS 75.15 (10)(c)	Words such as "manipulation" and "to punish" are too harsh. Re-word with less aggressive language. (#59, #67 and #70-72)	Agreed. The words "adjustment" and "sanction" have replaced those words.
HFS 75.15 (10)(g)	Although withdrawal planning (detox) may be a goal for treatment, it may take longer that the stabilization period for some to address treatment issues that would help prevent relapse to narcotic use. In general, detox is not recommended for patients who are pregnant, with hepatitis C, AIDS, or with a long history of narcotic dependence.	A change has been made to add relapse prevention.
HFS 75.15	Very hard to obtain courtesy dosing in the Chicago area. Phase II, III,	Has been deleted.

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(11)(a)(2)	IV should be allowed to use their hard earned status to visit the Chicago area without the need for courtesy doses.(#67 and #70-72)	
HFS 75.15 (11)(c)	Impractical to run to physician for approval, denial, or rescinding take home privileges. Counselors should document the reasons patient has lost take home privileges. (#67 and #70-72)	Agreed. "Signed" has been changed to "countersigned."
HFS 75.15 (11)(d)(6) b&c	References to "two years or three years" seem a contradiction to what is written on HFS 75.15(9) 5.d "A service shall provide narcotic addiction treatment to a patient for a maximum of 2 years, unless there is clear justification for longer service provision..." (#59, #67 and #70-72)	No change. There is not a contradiction because some patients may in fact be in treatment that long.
HFS 75.15 (11)(h)	Omit "at or above" since federal guidelines state above 100 mg., etc. (#59, #67 and #77-72)	Agreed. " At/or" has been deleted.
HFS 75.15 (11)(i) 1.	Omit "signs or symptoms of withdrawal", as this would be an unnecessary type of punishment for patients who have earned the privilege of receiving take home bottles. (#59, #67 and #70-72)	No change. If a patient is showing signs or symptoms of withdrawal, this would indicate that the patient is unstable and is in no position to handle or manage take home medications without increasing the risks during withdrawal.
HFS 75.15 (11)(n)	Delete "….and the designated federal agency///" (#59, #67 and #70-72)	Agreed. Change has been made.
HFS 75.15 (12)(b)	Clarify 2 week supply: 1 W/D + 13 T/O bottles or 1 W/D + 14 T/O bottles? (#59, #67 and #70-72)	Changed to a 14-day supply instead of the two-week supply.
HFS 75.15 (12)(d)	Delete "The service shall notify the state methadone authority of all exceptions including those of 2 weeks or less." SMA stopped this years ago. We call SMA for advice, recommendations or input. Request for exceptions continue to go through the physician for approval & are then filed in the patient's chart. (#59, #67 and #70-72)	Agreed. Change has been made.
HFS 75.15 (13)(b)	Delete "...at the time the person is admitted to the service," it is unnecessary to draw blood for methadone levels before the patient is receiving methadone. Would like it to read "after the patient stabilizes..." (#67 and #70-72) 2) A peak and trough at the time a patient is ready for Phase 2 is more logical and shows a good baseline level for a patient showing some success in using methadone. (#59) 3) Serum methadone levels are not relevant on admission, as they would not represent stabilized levels. (#44)	This has been revised to state that blood testing upon admission is to determine drug levels in plasma or serum so that there will be a baseline. Changed to after the patient's dose is stabilized.
HFS 75.15 (13)(c) 1.	1) Should be reworded to say "A urine specimen shall be randomly collected & tested on a random basis."(#59, #67 and #70-72) 2) Urine specimens are collected at random weekly, biweekly, or monthly depending on the patient's length of time & stability in treatment. (#44)	No change. A urine specimen is to be collected every day in the clinic and tested randomly.
HFS 75.15	Omit words "Patient's adamant denial" and "seriously", and add that	Modified to remove those words.

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(13)(d) 4.	the patient has the right to request a confirmation retest. (#59 #67 and #70-72)	
HFS 75.15 (14)(a)	Phrase ".... concerted effort to retain patients is contradictory to HFS 75.15 (9)(d) ".... treatment to a patient for a maximum of 2 years..." (#59, #67 and #70-72)	Agreed. Changed to read: "The service shall make a concerted effort to retain patients within the first year following admission."
HFS 75.15 (14)(c)	Once again, why use 2 years maximum when statements are made ..."continue treatment for up to 2 years or for as long as the patient benefits from treatment" and etc. (#67 and #70-72)	Agreed. HFS 75.15 (14) (c) has been deleted.
HFS 75.15 (16)(c)	1) Concerned about the requirement that pregnant women see a perinatal specialist or obstetrician before being admitted. Not being admitted could mean no addiction treatment or prenatal health care. A referral should be made. (#53 #67 #70-72) 2) Omit "before the service initiates addiction treatment." Concerned with time it takes to obtain an appointment with a perinatal specialist. If a pregnant patient is seen by her family physician and our physician, we could work with her in obtaining a specialist consultation. This will best serve patient and baby. (#59) 3) If pregnant patient is without a physician, she should be referred to a high-risk center not only for obstetrical but also for help obtaining medical assistance. Then she can get prenatal care & treatment for narcotic addiction. (#44)	Change has been made to reflect urgent need to coordinate services for pregnant women.
HFS 75.15 (16)(h).	Delete "arrange" and replace with "make referrals." (#67 and #70-72)	No change. "Arrange" better fixes responsibility for obtaining appropriate assistance for pregnant patients.
HFS 75.15 (17)(c)	1) Concerned about cost to patients if we test at admission & annually for viral hepatitis. If a person tests positive for hepatitis, there is no need for re-testing. (#67 and #70-72) 2) Testing for viral hepatitis & STD upon admission is appropriate. Referral should be made upon receiving a positive result. (#59)	No change. Death risk is too great.
(HFS 75.15 (17)(d)	Add that documentation of refusal to be immunized should be recorded in the patient's health record. (#59)	Agreed. Change has been made.
HFS 75.15 (19)(e).	What is meant by "reliable reports of diversion"? Unfair to patients who are successfully following their program. (#67 and #70-72)	Changed. The word "reliable" is deleted.
Appendix B	Smaller organizations do not have a psychologist on staff. (#3)	Appendix B refers to the qualification of mental health professionals. Staff of a service who provide mental health treatment services to dually diagnosed patients must meet the qualifications but a psychologist is not specifically required.